(c) In the event of a change in nursing facility provider ownership, ownership structure (including mergers, exchange of stock, etc.), provider, operator, lessor/lessee or any change in control, a completed Checklist of Management Representations Concerning Change in Ownership shall be submitted to the office or its contractor. The completed checklist shall include all supporting documentation. No Medicaid rate adjustments for the nursing facility shall be performed until the completed checklist is submitted to the office or its contractor.

405 IAC 1-14.6-6 Active providers; rate review; requests due to change in law

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 6. (a) The normalized average allowable cost of the median patient day for the direct care component, and the average allowable cost of the median patient day for the indirect, administrative and capital components shall be determined once per year for each provider for the purpose of performing the provider's annual rate review.

(b) The normalized allowable per patient day cost for direct care, and the allowable per patient day costs for the indirect care, administrative, and capital components shall be established once per year for each provider based on the annual financial report.

(c) The rate effective date of the annual rate review shall be the first day of the second calendar quarter following the provider's reporting year end.

(d) Subsequent to the annual rate review, the direct care component of the Medicaid rate will be adjusted quarterly to reflect changes in the provider's case mix index for Medicaid residents. If the facility has no Medicaid residents during a quarter, the facility's average case mix index for all residents will be used in lieu of the case mix index for Medicaid residents. This adjustment will be effective on the first day of each of the following three (3) calendar quarters beginning after the effective date of the annual rate review.

(e) The case mix index for Medicaid residents in each facility shall be updated each calendar quarter and shall be used to adjust the direct care component that becomes effective on the second calendar quarter following the updated case mix index for Medicaid residents.

(f) All rate-setting parameters and components used to calculate the annual rate review, except for the case mix index for Medicaid residents in that facility, shall apply to the calculation of any change in Medicaid rate that is authorized under subsection (d).

(g) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office.

405 IAC 1-14.6-7 Inflation adjustment; minimum occupancy level; case mix indices

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 7. (a) For purposes of determining the average allowable cost of the median patient day and a provider's annual rate review, each provider's cost from the most recent completed year will be adjusted for inflation by the office using the methodology in this subsection. All allowable costs of the provider, except for mortgage interest on facilities and equipment, depreciation on facilities and equipment, rent or lease costs for facilities and equipment, and working capital interest shall be increased for inflation using the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index as published by DRI/McGraw-Hill. The inflation adjustment shall apply from the midpoint of the annual financial report period to the midpoint prescribed as follows:

Effective Date	Midpoint Quarter
January 1, Year 1	July 1, Year 1
April 1, Year 1	October 1, Year 1
July 1, Year 1	January 1, Year 2
October 1, Year 1	April 1, Year 2

(b) In determining prospective allowable costs for a new provider that has undergone a change of provider ownership or control through an arms length transaction between unrelated parties, when the first fiscal year end following the change of provider ownership or control is less than six (6) full calendar months, the previous provider's most recently completed annual financial report shall be utilized to calculate the new provider's first annual rate review. The inflation adjustment for the new provider's first annual rate review shall be applied from the midpoint of the previous provider's most recently completed annual financial report period to the midpoint prescribed under subsection (a).

(c) The normalized average allowable cost of the median patient day for direct care costs and the average allowable cost of the median patient day for indirect care, administrative and capital-related costs shall not be less than the average allowable cost of the median patient day calculated at the time of implementation of this rule.

(d) Allowable costs per patient day for capital-related costs shall be computed based on an occupancy level equal to the greater of ninety-five percent (95%), or the provider's actual occupancy from the most recently completed historical period.

(e) The case mix indices (CMIs) contained in column A in this subsection shall be used for purposes of determining each resident's CMI used to calculate the facility-average CMI for all residents. The CMIs contained in column B in this subsection shall be used for purposes of determining each Medicaid resident's CMI used to calculate the facility-average CMI for Medicaid residents, except for Medicaid residents who are not eligible for Medicare Part B benefits, in which

case the CMIs contained in column A shall be used for those residents.

	RUG-III	CMI Table	
RUG-III Group	Code	A	B
Special Rehabilitation	RVC	3.35	2.10
Special Rehabilitation	RVB	2.77	1.50
Special Rehabilitation	RVA	2.76	1.32
Special Rehabilitation	RHD	2.68	2.00
Special Rehabilitation	RHC	2.19	1.49
Special Rehabilitation	RHB	2.02	1.39
Special Rehabilitation	RHA	1.91	1.27
Special Rehabilitation	RMC	2.34	1.90
Special Rehabilitation	RMB	1.83	1.34
pecial Rehabilitation	RMA	1.74	1.27
Special Rehabilitation	RLB	1.43	1.23
Special Rehabilitation	RLA	1.27	1.07
Extensive Services	SE3	5.06	5.06
Extensive Services	SE2	2.91	2.91
Extensive Services	SE1	2.05	2.05
Special Care	SSC	1.52	1.52
Special Care	SSB	1.38	1.38
Special Care	SSA	1.35	1.35
Clinically Complex	CD2	1.20	1.20
Clinically Complex	CD1	1.15	1.15
Clinically Complex	CC2	1.05	1.05
Clinically Complex	CC1	0.99	0.99

Clinically Complex	CB2	1.02	1.02
Clinically Complex	CB1	0.91	0.91
Clinically Complex	CA2	0.91	0.91
Clinically Complex	CA1	0.77	0.77
Impaired Cognition	IB2	0.86	0.86
Impaired Cognition	IB1	0.78	0.78
Impaired Cognition	IA2	0.69	0.69
Impaired Cognition	IA1	0.60	0.60
Behavior Problems	BB2	0.86	0.86
Behavior Problems	BB1	0.77	0.77
Behavior Problems	BA2	0.62	0.62
Behavior Problems	BA1	0.54	0.54
Reduced Physical Functions	PE2	0.96	0.96
Reduced Physical Functions	PE1	0.92	0.92
Reduced Physical Functions	PD2	0.90	0.90
Reduced Physical Functions	PD1	0.85	0.85
Reduced Physical Functions	PC2	0.78	0.78
Reduced Physical Functions	PC1	0.77	0.77
Reduced Physical Functions	PB2	0.68	0.68
Reduced Physical Functions	PB1	0.63	0.63
Reduced Physical Functions	PA2	0.60	0.60
Reduced Physical Functions	PA1	0.50	0.50
Unclassifiable	BC1	0.48	0.48
Delinquent	BC2	0.48	0.48

405 IAC 1-14.6-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 8. (a) Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations or fundraising or to encourage patient utilization.

(b) Each facility and home office shall be allowed only one (1) patient care-related automobile to be included in the vehicle basis for purposes of computing the average historical cost of property of the median bed. As used in this subsection, "vehicle basis" means the purchase price of the vehicle used for facility or home office operation. If a portion of the use of the vehicle is for personal purposes or for purposes other than operation of the facility or home office, then such portion of the cost must not be included in the vehicle basis. The facility and home office are responsible for maintaining records to substantiate operational and personal use for one (1) allowable automobile. This limitation does not apply to vehicles with a gross vehicle weight of more than six thousand (6,000) pounds.

405 IAC 1-14.6-9 Rate components; rate limitations; profit add on

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 9. (a) The Medicaid reimbursement system is based on recognition of the provider's allowable costs for the direct care, indirect care, administrative and capital components, plus a potential profit add-on payment. The direct care, indirect care, administrative, and capital rate components are calculated as follows:

(1) The indirect care, administrative, and capital components, are equal to the provider's allowable per patient day costs for each component, plus the allowed profit add-on payment as determined by the methodology in subsection 9(b).

(2) The direct care component is equal to the provider's normalized allowable per patient day costs times the facility-average case mix index for Medicaid residents, plus the allowed profit add-on payment as determined by the methodology in subsection 9(b).

(b) The profit add-on payment will be calculated as follows:

(1) For the direct care component, the profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the normalized average allowable cost of the median patient day for direct care costs times the facility average case mix index for Medicaid residents times 105%, minus

(B) a provider's normalized allowable per patient day costs times the facility average case mix index for Medicaid residents.

(2) For the indirect care component, the profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times one hundred percent (100%), minus

(B) a provider's allowable per patient day cost.

(3) For the administrative component, the profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times one hundred percent (100%), minus

(B) a provider's allowable per patient day cost.

(4) For the capital component, the profit add-on is equal to sixty percent (60%) of the difference (if greater than zero (0)) of:

(A) the average allowable cost of the median patient day times eighty percent (80%), minus

(B) a provider's allowable per patient day cost.

(c) Notwithstanding subsections 9(a) and 9(b), in no instance shall a rate component exceed the overall rate component limit defined as follows:

(1) the normalized average allowable cost of the median patient day for direct care costs, times the facility-average case mix index for Medicaid residents times one hundred ten percent (110%).

(2) the average allowable cost of the median patient day for indirect care costs times one hundred percent (100%).

(3) the average allowable cost of the median patient day for administrative costs times one

hundred percent (100%).

(4) the average allowable cost of the median patient day for capital-related costs times eighty percent (80%).

(d) In order to determine the normalized allowable direct care costs from each facility's Financial Report for Nursing Facilities, beginning with the first financial report submitted to the office or its contractor under this rule, the office or its contractor shall determine each facility's CMI for all residents on a time-weighted basis.

(e) The office shall publish guidelines for use in determining the time-weighted CMI. These guidelines shall be published as a provider bulletin, and may be updated by the office as needed. Any such updates shall be made effective no earlier than permitted under I.C. 12-15-13-6(a).

405 IAC 1-14.6-10 Computation of rate; allowable costs; review of cost reasonableness

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 10. (a) Costs and revenues, excluding non-Medicaid routine revenue, shall be reported as required on the financial report forms. Allowable patient care costs shall be clearly identified.

(b) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

(c) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers throughout the state. The office or its contractors may request satisfactory documentation from providers whose costs do not appear to be accurate or allowable.

(d) Indiana state taxes, including local taxes, shall be considered an allowable cost. Personal or federal income taxes are not considered allowable costs.

405 IAC 1-14.6-11 Allowable costs; services provided by parties related to the provider.

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2